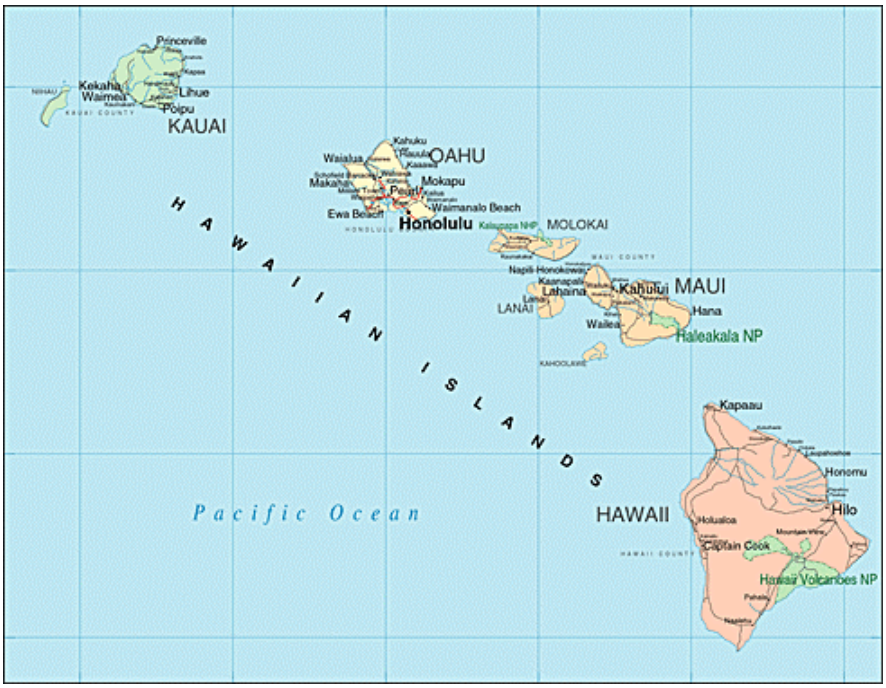
UNIVERSITY OF CALIFORNIA SAN FRANCISCO
CHILD SERVICES RESEARCH GROUP (CSRG)

REFLECTIONS ON EVALUATION: HAWAII DEPARTMENT OF PUBLIC HEALTH'S CHILD AND ADOLESCENT MENTAL Health Division (CAMHD)



FUNDED BY: HAWAII DEPARTMENT OF PUBLIC HEALTH'S CHILD AND ADOLESCENT MENTAL Health Division (CAMHD)

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Background and Overview

This report summarizes a review of the evaluation research system currently in place in Hawaii Department of Public Health's Child and Adolescent Mental Health Division (CAMHD). The University of California, San Francisco Child Services Research Group conducted the review at the request of the CAMHD. The goals of the review were to: 1) examine the current evaluation system and summarize its advantages and disadvantages; 2) provide consultation regarding how to maximize the value of the current system, and 3) provide options for future directions. This report focuses primarily on the first and third goals, summarizing the current system and providing options for future development. The second goal will be pursued further with CAMHD as the next of this project.

The services provided by the CAMHD are diverse, and include a range of interventions and programs. The range of potential outcomes and indicators for an evaluation of such a system is similarly broad and varied. Consequently any program of evaluation research conducted under such circumstances necessarily involves making choices regarding emphases and direction. These choices are often driven by the goals of the service system, by the audiences for the information, as well as by pragmatic considerations. This report will provide alternate or complimentary methods and strategies for the evaluation of the services provided by CAMHD, not so much because of inherent weaknesses in the system but rather in an attempt to help CAMHD staff consider additional options for evaluation research. This review utilized interviews with key stakeholders, CAMHD staff as well as an examination of CAMHD evaluation materials and reports. The basic findings review will be presented. Recommendations will be presented for future directions.

Methods

Open-ended discussions were conducted with CAMHD providers, CAMHD leadership and evaluation staff, family representatives, and representatives from the education, juvenile probation, and social welfare systems. These discussions were designed to allow for stakeholders to provide their views on the current evaluation system and their perspectives on the types of evaluation information that are most valuable to their work. In addition, a wide range of documents were also reviewed, including: Clinical Report and Coordinated Service Planning Report Examples; Annual Performance Report FY 2002; Interagency Sustainability Report FY 2003 Q1 & Q2 – Q3; Sustainability Data Report FY 2003 Q4; Child Status Measure Completion Study; and Consumer Survey Reports.

Findings

The findings presented in this section of the report derive from interviews and reviews of written materials. There was considerable consistency between various sources of information regarding the basic structure and goals of the services provided by CAMHD and of the evaluation system that is currently in place. Opinions regarding the strengths

and challenges of the current system, as well as priorities for the future development of the evaluation process did vary by source. These differences of opinion will be acknowledged when they occur.

A broad overview of the current status and future directions of CAMHD Services

The characteristics of an evaluation system are, at least in part, determined by the structure of the service system. Many of the stakeholders mentioned that the services provided by CAMHD are clearly in flux and likely entering a period of significant change. It is possible that the Felix consent decree will either end or be altered this year, resulting in budgetary and funding changes for children's mental health services in Hawaii. In addition, Mental Health is moving toward a health plan model that will result in changes in business practices. It is likely that these and other modifications in the service delivery structure will create a more interdependent role for CAMHD, both within behavioral health services including adult mental health and substance abuse; and with regard to collaborative agencies such as probation, education, and social welfare. Such changes are likely to create additional challenges and opportunities for the evaluation of services provided by CAMHD.

The current evaluation system clearly grew out of a less interdependent environment where the Felix Consent Decree largely drove CAMHD services. The current management information system also was initially created predominantly out of the needs of the Felix consent decree. Under Felix, CAMHD had access to a relatively protected funding stream and a mandate to increase access and expand the services provided to youth with mental health needs in Hawaii. The system grew and evolved rapidly during the 1990's, with the creation of a continuum of care and over 8,000 youth being served. Subsequent to the establishment of fundamental services, evidence based treatments and practices were introduced with the goal of improving the quality of and outcomes of care. The use of evidence based practices remains a strong characteristic of CAMHD and significantly influences the characteristics of the current evaluation system. When the consent decree ends, the budget for children's mental health services will almost certainly be reduced relative to the period of growth, and the need will likely be created for continued and heightened efficiencies.

CAMHD staff acknowledged that the system would, in the future, likely need to convert youth who are eligible to QUEST (the health plan system), and to encourage linkages to other agencies such as substance abuse, juvenile corrections and social services.

There is currently significant movement toward enhancing links between partner agencies. The Branch chiefs meet regularly; there is movement toward data sharing, and encouragement within the department of behavioral services to increase collaboration between the adult, child, and substance abuse systems.

Description of the current evaluation system

The existing evaluation system mirrors those found in many other states in its use of measures of functional status and symptomatology such as the Child and Adolescent

Functional Assessment Scale (CAFAS) and different versions of scales developed in Vermont by Achenbach (the Child Behavior Checklist, Youth Self Report, and Teacher Report Forms). Other measures include an assessment of client satisfaction and the CALOCUS that focuses on living environments. The system, however, is exceptional in two key ways: 1) The creative and skillful methods being established to package and use information from these measures for clinical decision making; and (2) The creative integration of management information system data on service utilization with measures of functional status to create clinical decision making tools.

The Felix Consent Decree has driven the evaluation system at CAMHD. The decree included court oversight of services delivered by both the Department of Education (DOE) and CAMHD where DOE delivers school based services (e.g. assessment, special education, & outpatient) and CAMHD brokers high-end services through a network of treatment providers. Evaluations have focused heavily on service appropriateness, timeliness, and quality, and less so on system integration with DOE and other partner agencies. Five of the nine statewide performance measures are directly related to service, with two others dominated by service concerns focusing of personnel and stakeholders. Billing and infrastructure round out the nine performance areas.

Service level evaluation measures include billing, frequent outcome assessment (e.g. CBCL), sentinel events reporting (e.g. client event of physical assault, institutional event of medication error), program performance indicators completed by providers of various types (e.g. hospital treatment, Intensive In-Home), and case-based reviews on randomly selected youth served by each provider. Much of the individual level data is available on a day-to-day basis as decision support for clinical directors and other staff (e.g. dashboard clinical reports), monthly in aggregate form to monitor branch performance, and/or rolled-up various levels (e.g. provider, branch) for inclusion in reports (e.g. annual performance report) that inform policy and strategic planning.

System level measures include monitoring data collection performance on the various individual level measures of service, case-based reviews having a large interagency component with DOE, and utilization management reports on placements. System level information about who does what, where, and how often is not monitored as extensively as services, however significant efforts have been made to create policies and procedures to set the ground rules for system interaction. For example, “the green book”, as it is termed, outlines rights of consumers and the responsibility of multi-agency staff, however the focus is again clearly at the service level.

Viewpoints on the Evaluation from Within CAMHD

There was considerable variation from service providers within CAMHD regarding the current evaluation system. The current evaluation system was generally viewed as being created at least in part by the needs of the consent decree and to provide data to the courts. Most felt that clinical outcome measures such as the CBCL, YSR and CAFAS were completed for compliance reasons in the past, and that now an effort was being made to integrate these measures into clinical practice.

Perspectives on the Strengths and uses of the current system

Several respondents felt that this evolution has been at least partially successful. Respondents noted that the measures, along with other information, help them to monitor population changes and staffing needs. Some respondents viewed caseload reports as particularly helpful. A "Clinical Dashboard" that was recently developed also received unanimous praise as did a sentinel events-tracking process. The clinical dashboard was being used to make service decisions and seemed to clarify benchmarks and treatment goals. In general, it was clear that considerable progress in utilizing outcome and management information data had been recently made.

Other positive comments regarding the evaluation system included:

- People have developed an internalized evidenced-based approach and being forced to work with education has helped cooperation with DOE.
- There is greater access to information and the increased feedback to Care Coordinators has decreased complaints
- There is an improved accountability with providers where treatment is more time limited.
- Evidenced-based treatment provides a basis for making decisions to limit treatment that would have otherwise continued.
- Progress is now demonstrable.
- Outcomes might be a way to attract cooperation between agencies.
- There is greater appreciation of evidenced-based treatment and better communication with MIS

Finally, while a centralized evaluation system within CAMHD forms the core of what information and data are collected, there is also considerable variability by provider. Many providers collected additional information designed to meet the special needs of their clientele and services. These included: Obtaining grades and attendance information on a case by case basis, tracking re-arrests and recidivism and other juvenile justice indicators, tracking placements, and information on length of stay.

Perspectives on the Challenges Posed by the Current System from within CAMHD

Interviewees did note that the evaluation process posed challenges, mostly having to do with differences in perspective regarding essential and important information and on the value of data collection as currently designed. There were several comments regarding the burden posed by the current evaluation system, particularly the Achenbach measures.

Several respondents questioned why the Achenbach and other measures were being administered at three-month intervals when the measure itself reflects a six-month time frame. Respondents also emphasized difficulty in obtaining interagency data such as juvenile justice, social service, and education information. There were also questions regarding whether the data collection system as designed really matched the needs of specific populations, for example youth in the juvenile probation system who are wards of the court may not have an available caregiver for CBCL administrations. With this population, measures such as juvenile justice recidivism were considered of potentially more value than more mental health focused measures.

There were more specific comments as well, including:

- The sentinel events measure is based on a medical definition and is too specific. Each sentinel report is good for evaluating each individual event, and take action if necessary, but it is not clear what the overall count of events means. A higher rate of events may simply mean that the provider is being honest and conscientious in reporting, and another provider is under-reporting.

- There is a need for more paraprofessional involvement and training

- There is a need for evaluating transition services for youth who age out of CAMHD

- Caseload reports may not always be a fair measure of performance. Staff members felt demoralized when results were lower than other sites or centers.

- Staff felt they were not trained on the performance measures and were not asked for their input. They are not happy with the out of home placement, and they had no clue where the client satisfaction measure came from.

- Concerns were raised about whether measures such as caseload can be "gamed" to get positive results.

- Care coordinators know how individual youth are doing and don't feel they need the CAFAS.

- Increasing interagency information would help providers understand what works and how services are progressing.

- There is duplicated and redundant reporting with too much manual entry

Viewpoints from Juvenile Probation, Social Welfare, and Education

In general, representatives from the juvenile probation, social welfare, and education systems were appreciative of the efforts underway by CAMHD to evaluate services. However, all persons interviewed expressed the viewpoint that the evaluation focused

predominantly on mental health information rather than on cross agency data. Data sharing across agencies was clearly limited, and HIPAA provided further challenges to sharing confidential records. It was also clear that most other agencies collected extensive data for their own purposes, and that there was limited to no overlap between the data collected by these agencies and mental health data.

Specific comments from other agencies regarding the CAMHD evaluation included:

- The system evaluation is poor.
- Mental health does not account for the priorities of other agencies in the evaluation system
- Discussions began about sharing individual data with family court, DOE, and DOH, but mistrust put an end to those talks. Individuals sited HIPAA and FIRPA as obstacles, but trust was the real issue. Agencies are afraid of criticism if they show their data to other agencies.
- Agencies have no incentive to take the risk to share data, and when the benefit isn't clear they err toward not sharing

Summary of Evaluation Interviews

Over the course of the discussions, it became clear that there were a range of perspectives on potential priorities for the evaluation process within CAMHD. Comments were positive or negative, mentioned few times or more universally endorsement across level of staff. Table 1 presents a summary of the comments of staff regarding the evaluation system at CAMHD. Though some of this material is duplicative of issues already raised, the tables attempt to synthesize these issues into domain and respondent category.

Table 1 shows that respondents expressed an almost universal need for collaboration with DOE, Divisions of Adult Mental Health and Alcohol and Drug, and fellow agencies serving youth including the Office of Youth Services. Staff addressed measurement and implementation issues from having different expertise, experience, and responsibility. Responses reinforced the need to balance the trade-off between resources needed to obtain valid data on important benchmarks and the functional utility of the results from the data. Direct service staff expressed some concern over workload and measurement utility, while research and executive staff commented on ways to leverage the data. Overall, staff appreciated the clinical dashboard, and clinical staff appreciated its value as a decision tool, and were clearly expressing the desire to have more such tools.

Table 1. Comments from Interview Respondents on CAMHD Evaluation System

Domain	Respondents	Example of Respondent Comments	UCSF Perspective
Collaboration	Staff from all Levels	▪ Publish a shared definitive MH, ED position of data sharing incorporating HIPAA and FERPA ▪ Provider audits (e.g. service testing) should be done as a joint effort between MH and OYS ▪ Establish training to inform agencies of the data and potential use of data cross agencies ▪ Committing resources to assist in multi-agency issues can help protect CAMHD	These comments from interview respondents match recommendations made in this report for further considering interagency outcomes and perspectives in the CAMHD evaluation system.
Measurement, Implementation	Staff from All Levels	▪ Dashboard is useful and an improvement	The Dashboard is clearly an innovative and valuable addition to the evaluation process.
	Direct Service Staff	▪ Reduce duplicated manual data entry ▪ CBCL is very difficult to collect ▪ The care coordinators know how youth are doing and don't feel they need the CAFAS. ▪ CAFAS and CBCL have limited usefulness for clinical staff ▪ The dashboard makes clear the benchmarks for treatment. ▪ The clinical director uses the dashboard to make service decisions.	These comments reflect some suggestions in this report that describe how efficiencies could be created by altering the CBCL administration patterns. Direct service staff reinforces the utility of the Clinical Dashboard, a very innovative addition to the evaluation process.
	Research Staff and Other Agency Staff	▪ Improve evaluation by establishing a model of decision-making for CAMHD in the treatment setting ▪ Evaluation of the system of functioning between CAMHD and DOE, and other service partners needs to improve ▪ An examination of alternatives to incarceration	These comments by respondents from other service sectors generally reinforce the recommendations regarding increasing the interagency aspects of the evaluation process.

		would be useful ▪ An inclusion of measures important to supportive learning would be useful for DOE	
	Executive Staff	▪ Evaluate how the level of quality of service is sustained when youth/$ ratio increases ▪ Help interagency providers understand how services are going	Again, interview respondents emphasize interagency aspects of data collection. Quality of service is being monitored by the CAMHD evaluation.

Table 2 presents comments by staff on the CAMHD organization in general that have some relationship to evaluation. These comments were offered by staff as potential points of evaluation, obstacles to some aspect of evaluation, or measures to encourage evaluation. Though not directly related to the evaluation process, these concerns raise potentially important considerations for the CAMHD evaluation process over time.

Table 2. Comments from Interview Respondents about CAMHD Organization in Relation to Evaluation

Domain	Respondents	Example of Respondent Comments
Collaboration	Executive and Other Agency Staff	▪ Protect CAMHD by establishing high-level advocacy for mental health by encouraging and joining national advocates for children and families ▪ Make an effort to establish trust between agency partners ▪ Participate in shared projects, and devote resources to inter-agency issues in an effort to create interdependence
Funding	Staff from all Levels	▪ Its important to Convert Qualifying Youth to Quest, and attract new referrals for Quest
Funding	Executive Staff	▪ Changing Business Practices from Felix to Health Plan
Infrastructure	MIS	▪ A couple additional servers would greatly improve the speed of access to information
Services	Clinical Staff	▪ Transition Planning for youth aging out of MH system ▪ Expansion of Alcohol and Drug Treatment services to avoid waiting lists ▪ Improve efforts to identify “gap” youth

Summary of Findings

The Hawaii Child and Adolescent Mental Health Division clearly has a carefully developed and sophisticated evaluation system that evolved out of the needs and mandates of the Felix Consent Decree. There was clearly considerable appreciation of the

creative efforts currently underway to maximize the clinical and programmatic utility of the information, and an almost universal acknowledgement of the importance of evaluation in general. The strengths of the system are numerous, and include most predominantly a well-articulated plan for the use of the information, the use of state-of-the art measures and tools, and a strong commitment to using information to improve services. The existence of a strong Management Information System that collects utilization and cost data and the ongoing work to integrate the MIS with the outcomes systems are also among the most important aspects of the current system.

The challenges posed to the system include some dissatisfaction with the amount of work required to implement the system, some concerns about the fairness of the system, and questions about whether the system best captures the needs of special populations such as youth in juvenile probation, youth transitioning to the adult system, and youth with substance abuse needs. Concerns were also voiced regarding the accuracy and completeness of some data collection mechanisms. Finally, the system clearly emphasizes a mental health perspective on clinical outcomes, with relatively less emphasis on outcomes that are of interest to other agencies or outcomes that exist at the systemic level.

Discussion and Future Directions

The findings obtained in discussions with CAMHD staff and external stakeholders match our general perspective regarding the CAMHD evaluation system: This is a highly evolved mental health evaluation system with a predominant focus on the improvement of clinical practice. The system has improved significantly with the addition of new evaluation staff that has promoted increased use of the data for clinical decision-making, and a growing integration with management information data. There was universal appreciation for these improvements within CAMHD. As is always the case, there is, however, room for growth and further development within the system. There are two predominant directions in which this, or any system can be improved: 1) Refinement and enhancements of the current system, and 2) New directions for growth of the system, especially in light of likely evolutions in the service delivery system itself.

Refinements to the Current System

With regard to refinements and enhancements in the current system, the potential alterations are matters of emphasis and efficiency that reflect improvement and evolution rather than significant overhauls. At this point, the evaluation process is relatively labor intensive with regard to the quarterly administration of outcome measures, especially the Achenbach scales. It may be possible to move to six-month administrations of the Achenbach scales, with little loss of data. The CAFAS and CALOCUS are relatively less labor intensive, and could be administered on a quarterly basis to give quicker and more continual feedback. The key issue, one that remains vexing for sites around the nation, is how to obtain adequate response rates, especially with regard to follow-up, on scales such as the CBCL that require caregiver input. It would be potentially worthwhile to reduce

the amount of energy and resources required by quarterly administrations and put that effort into obtaining sufficient numbers of follow-up assessments.

The current move toward integrating data from the outcome and management information systems has the potential to exponentially improve the results that can be obtained form the information currently being collected. This opportunity represents a potential growth in emphasis, from clinical decision making to broader, more programmatic and policy oriented tools. Such integrations of data are typically fraught with programmatic and analytic challenges. The pragmatic challenges appear to have been largely overcome, leaving the analytic work as a potential major goal.

Other refinements in the system are relatively more minor, and have to do with the continual need to address concerns regarding the value, burden, and efficiency of the system as services to youth in Hawaii change.

Directions for Future Development

The second set of issues for the evaluation system is potentially more substantive in nature. The current evaluation system clearly grew out of the needs of the Felix consent decree and is, consequently, highly focused on mental health concerns. The predominant strength of the system is the manner in which it is optimized to provide clinical support to the delivery of mental health services. It is not too strong to state that in this regard, the CAMHD system is a potential model for other sites nationwide. Given the considerable strength and sophistication of the current system, there is some risk in suggesting potential future directions that would represent alterations of the current direction. The potential risk is that any evaluation system is created within constrained resources and that those resources can be spread too thin, resulting in a system that tries to do too much and loses its focus.

Nonetheless, it is clear from the discussions that the evolution of the services provided by CAMHD may create the need for additional types of information. In addition, it is clear that other agencies have information needs that vary from those of mental health. In a more interdependent environment, there can be a value in addressing those needs. Consequently, the goal of these recommendations is to provide a range of options that can be considered by CAMHD staff for modifications to their current system.

Interagency Context

In general, the measures and outcomes assessed by the CAMHD evaluation system focus on clinical and functional status measures that are of primary interest to mental health. Other measures of primary interest to partner agencies receive considerably less emphasis. This is certainly understandable, after all CAMHD provides mental health services to persons with mental health needs. However, if CAMHD becomes more interdependent with partner agencies for service delivery strategies, there could be considerable value to broadening the evaluation system to include these concerns.

Measures of particular interest to partner agencies include: arrests and juvenile justice recidivism, educational achievement and attainment, rates of out-of-home placement, substance use, and child protective services involvement. Partner agency representatives, as well as some within CAMHD who work with these populations frequently mentioned these measures. These indicators of whether youth are "in home, in school, and out of trouble" as we've termed it have the additional potential value to capture domains that are more easily explainable to a wider range of audiences than scales such as the CBCL and CAFAS which tend to appeal predominantly to clinical staff or mental health related audiences.

Policy Context

The indicators currently collected by CAMHD provide critical policy information in the context of the Felix Consent Decree. However, in the broader policy arena post Felix, additional measures may prove essential. With regard to outcomes or effectiveness, measures of safety and welfare are especially germane to the policy arena. Public perceptions of safety and public health undeniably drive part of the mental health policy debate. As a result, interventions that hope to impact on policy need to strongly consider measuring variables such as arrest rates, suicide rates, and rates of co-morbid conditions such as drug use. Many interagency-based measures are likely to have important policy implications.

In addition, policy decisions are especially likely to be driven by concerns of access or equity and of efficiency. Efficiency, relates to both producing services at the lowest cost and maximizing health given constrained resources. Equity relates to health disparities and the fairness and effectiveness of procedures for addressing these inequities. The current CAMHD system does provide some indicators of access (numbers of youth served, penetration rates into other agencies) and of efficiency (cost per youth served). However, future development along these lines may be possible as well, especially with regard to equity and cost within an interagency perspective.

Practice, Program, and System Level Evaluation

Although human service systems can be analyzed from a wide range of perspectives, current research on care systems tends to focus on three levels of analysis: (1) the systems level, (2) the programmatic level, and (3) the practice level (Rosenblatt, 1998). The systems level refers to the structure, organization, and financing of services. Care Systems are also composed of program-level interventions that can include traditional clinical services (such as outpatient and inpatient care) or more innovative, integrated services (such as therapeutic foster care, case management, and special day school programs). Regardless of the level of innovation at the program or system level, the ultimate success of any care is at least in part dependent on what occurs at the practice level. This level refers to the ways in which care providers interact directly with children, their families, and their support systems.

The current CAMHD evaluation system is exceptionally strong and can even potentially serve as a national model for practice level evaluation strategies. Programmatic

evaluation is also underway. However, relatively less systems level evaluation is being conducted, especially with regard to the evaluation of interagency goals. For example, an interagency policy team could put in place strategies for avoiding unnecessary placements for the state, and those strategies could be evaluated through the use of statewide placement rates. The general lack of systems evaluation is largely due to relatively less emphasis under the Felix consent decree on those concerns, however, future developments in the services provided by CAMHD may create more opportunities for interagency and system level interventions and their evaluation.

Conclusions

Any evaluation system exists within an environment of resource constraints. An evaluation of the services provided by a state entity such as CAMHD requires making trade-offs between different emphases and goals. The current CAMHD evaluation system is a product of such trade-offs and cannot, in either the present or the future, meet all the needs of all the stakeholders. The current CAMHD system is notable as an outstanding attempt to bring evaluation and research into the practice of caseworkers and line level staff. Few other such systems exist nationwide, and there is considerable opportunity for this effort to improve the quality of services that are provided to youth.

There is some risk in pointing out areas for growth in the current evaluation system: given resource limitations, moving into new areas could impede or retard the exceptional progress already made by CAMHD staff in evaluating their services. However, services are evolving within CAMHD, and it may be possible to similarly evolve and grow the evaluation system without compromising the progress that is already underway. Should this be possible, then growth can occur in the following areas: The broadening of outcome domains to include indicators of interest to partner agencies, including juvenile justice, education, social welfare, as well as substance abuse services and adult mental health; an increasing emphasis on indicators of efficiency and equity; and an increasing emphasis on system level evaluation. This could drive the evaluation system to increase the emphasis on interagency needs and on policy relevant information.

If such growth could be achieved without the loss of the exceptional mental health related practice information that is currently in place, then the system would have the opportunity to be more informative to a broader range of audiences. However, care must best taken if such directions are chosen to not compromise the progress already made.